TESTIMONY OF PATRICIA A. McLAUGHLIN, M.D.

BEFORE

SENATE STANDING COMMITTEE ON HEALTH

SENATE STANDING COMMITTEE ON INSURANCE

JANUARY 13, 2014

Good afternoon and thank you for allowing me to address this Committee from the standpoint of the impact the implementation of the Affordable Care Act had on my small business which also happens to be a medical practice. My name is Patricia A. McLaughlin, M.D. and I have a solo practice in New York City, specializing in the field of ophthalmology.

While I am supportive of the goal of providing access to health insurance for all, my personal experience and perspective as a physician and small business owner has lead me to conclude that the present construct is deeply flawed. It defies common sense that the ACA law attempts to provide coverage for millions of new patients, and yet allows insurance companies the right to create new limited networks of providers and facilities. This can only serve to delay and limit access to health care. In many cases, such as my own example, these limited networks have been created by excluding currently credentialed physicians from participation. The physicians, who have been included in ACA network plans, will face dramatic cuts in reimbursement from the insurance companies, to the point where the very viability of their business will be threatened. The fiscal collapse of medical practices will certainly be counterproductive to the goal of wider healthcare access.

Everyone covered by my small business plan's health insurance had good experiences over the years. We had an Empire BCBS PPO plan with a high deductible and it allowed for HSA funding. We were comfortable with the fact that our coverage had both in and out-of-network benefits,

as is meant by the PPO classification. Referrals were not required. The participating physician network was robust and rarely was there a need to see a physician out-of-network, unless that was by choice. We appreciated the freedom of this choice. I had no intention to change from this health insurance coverage. We renewed year after year and dealt with slight increases in premiums annually.

Our policy's anniversary date was on the first of January. When a letter arrived from the insurance carrier 90-days prior to the anniversary date, I was shocked to read that the plan was not going to be renewed, as it had been in previous years. To say that the rug was pulled out from under me is an understatement. The reason given was that my plan was not in compliance with the ACA requirements. This was a comprehensive PPO plan from a national insurance company. To this day, I do not understand what may have been deemed deficient by the ACA regulations to prevent it from being 'grandfathered.'

The letter from the insurance company went on to state that they were in the process of rolling out a new plan; one that would be close to what I currently had, and that it would be ACA compliant. Unfortunately, they were not prepared to discuss the new plan with me at that time and that I was to expect a second letter before my anniversary date that would outline the new benefits. In the meantime, I was referred to the New York Exchange Marketplace in case I wanted to explore those options. Within a month, the new plan was revealed in the second letter. Clearly it was not as good as the one cancelled.

The new plan was an EPO, not a PPO. We were to lose the ability to use an out-of-network physician or facility, unless we chose to do so outside any insurance involvement. For giving up this significant benefit, I was surprised to learn that the premium would only decrease 2.5% while the in-network deductible for the new plan was going to increase by $500.00 to $2500.00

representing a 20% increase. The problem with the deductible increasing is that it causes a financial strain on the member and applies to medications, medical office visits for acute and chronic care, laboratory and diagnostic tests, ER visits, physical therapy, etc. After the deductible would be satisfied, the co-insurance cost-sharing was to remain constant at 20%. The other oddity to this new Empire EPO (in-network only) plan was that the company was now going to require referrals to access specialists. Prior to 2014, the Empire EPO plans never required referrals. Only the company's HMO plans had that requirement and those plans cost considerably less than either the PPO or EPO plans. The confounding issue is that the newly rolled-out EPO (Essential Guided Plus) for small businesses is that it does not follow the 'grandfathered' EPO plan benefits involving network of participating physicians, formulary medications, and the referral requirement.

The real problem with the new plan, and one that most other small business administrators may not have been aware of, was the change in physician network to one with considerably less participating network physicians and a new, more restrictive medication formulary. As a physician, this was something that I was able to see instantly. This new Empire BCBS network was given the name: "PATHWAY." As it turns out, "PATHWAY" is the network to be used for the BCBS Exchange plans and for small business plans in NYS. My employees quickly discovered that they were not going to be able to see their primary care physician or specialists that he recommended, because the PATHWAY network no longer included them. As a matter of fact, I, too, learned that the insurance company, "as per the terms of my contract," would not be offering me, a current EPO/PPO network physician, participation in "PATHWAY, PATHWAY ENHANCED, OR PATHWAY X." However, the insurance company would allow me to remain in their previous network that currently insures larger businesses, self-funded corporate plans, federal employees, and certain union plans that received a pass extension for another year (such as the 32 BJ Union employees). The irony is that, as a physician, I was not allowed to participate as a network provider of care in the very insurance that the company felt was

equivalent to the cancelled plan and was to be the insurance for my small business as of 1/1/14. I ask: "Why is one EPO plan discriminated against and given such inferior benefits compared to 'grandfathered' EPO plans within the same insurance company?"

At no time did the insurance company indicate that this new plan for my small business was part of "The Exchange." I was told that if I wanted to roll-over into this new plan, no further action was required on my part. New insurance cards would be sent out and a new benefit manual would be forthcoming. Interestingly, now that we have passed the first 10-days of January, none of us have received new insurance cards or the new benefit manual. Should we need to access care, we don't even know our new member ID numbers. Furthermore, if we went to see one of our previous physicians, and they saw us without the new card, they would not know that we are restricted to the "PATHWAY' network or that we needed a referral to see a specialist. The claim would be denied if filed by a non-participating physician. Essentially, we would be liable for the cost of medical care and since it would be outside the participating network, this cost would not apply against the deductible or out-of-pocket maximum. Since I was an existing subscriber and not a last minute enrollee, there is no reason for such poor preparation and lack of readiness on the part of the insurance company. Doctors and patients are going to be adversely affected by this negligence. Members need their insurance cards, and the medical community needs to see these cards to verify insurance eligibility and to file the claim with the insurance company.

I am further outraged to learn from the insurance automated system, that this new plan identifies my group as a "healthcare Exchange member." Previously, I had a small business plan obtained through a broker. I never asked to be part of "The Exchange" or to have limitations placed upon my choice of participating physicians or to have a more restrictive medication formulary.

Now from the standpoint of this plan being called an “EPO” how is any physician’s office going to be able to differentiate over the telephone, as a patient calls in to schedule an appointment, a new “EPO” from a “grandfathered EPO?” My office staff and I will likely be met with patients not having new member ID cards and won’t be able to reassure the patient if I am participating or not in their particular EPO plan. This system is intolerable and something must be done to protect both the patient and the physician from such a confusing situation. It defies logic that the insurance company is cherry picking participating physicians and assigning them to EPOs from different sub groups (Exchange vs. non-Exchange).

Also from a medical business standpoint, the 90-day grace period is problematic. Certainly, there must have been good intentions to allow Exchange patients the ability to fall behind in premium payments and to protect them from losing their insurance. However, in all fairness to the medical community, then we, too, need to be protected when we are seeing a patient in the grace period. Real-time adjudication is absolutely needed. This protection is given to pharmacies as they know at the time the medication is dispensed, the amount of deductible or co-insurance needed to be collected from the patient. I must request that this help be extended to the medical community, not only for the 90-day grace period, but for any patient with an unsatisfied deductible. As a small business, we also have to cover overhead expenses and be fiscally responsible to our creditors. If an account receivable gets out of control, the office may well run in the red and ultimately close operations. This would be a great disservice to the community as a whole.

From the patient perspective, greater transparency is needed. While many ACA plans seem to emphasize reduced monthly premiums, they also include very high annual deductibles. The financial responsibility for payment of these “first dollar” amounts will greatly burden patients,

many of whom have no prior experience with high deductibles as they have had no insurance at all, or have had plans with no or low deductibles. Reports have indicated that many patients are obtaining plans based on premium cost only, disregarding the impact of the deductible. The alternative, within the ACA, are plans with lower deductibles, but much higher monthly premiums. There really is very little "choice" when you look at it, but either way, the concept of affordability is questionable. Studies have shown that patients delay obtaining care when faced with up-front high deductible costs. Delayed care leads to more serious medical conditions and ultimately causes higher medical costs.

True choice was all but eliminated with the vast majority of plans being underwritten as in-network only plans. Given the restricted physician and hospital networks of the small business and ACA plans, this may be a problem for patients, especially those transferring from prior plans that allowed such benefits. In many instances, patients will lose access to their current doctors, as exemplified by my own situation. If a patient should choose to see an out-of-network physician, the expense would be totally theirs. The costs will not even be applied to their deductible or maximum out-of-pocket expense. Almost all insurance companies, today, that offer out-of-network benefits, have shielded themselves from exorbitant costs by limiting the benefit to a percentage of the published CMS Medicare fee schedule (110% - 140%). It would be helpful to patients if this practice be extended to all small business and individual ACA plans.

Thank you for allowing me to provide you with this information. I welcome your questions and offer my help should you wish to reach out to me in the future.